

THE MEDICAL EXAMINER,

And Retrospect of the Medical Sciences.

Vol. VI.]

PHILADELPHIA, SATURDAY, FEBRUARY 4, 1843.

[No. 2.]

A COURSE OF CLINICAL LECTURES, Delivered at the Hôtel Dieu, Paris, for the Session 1842-'43.

BY A. F. CHOMEL, M. D.

LECTURE I.

[Translated for the Medical Examiner.]

CASE I. Chronic Meningitis, with slight Hemiplegia—Symptoms of Compression—Death—Considerable Serous Effusion in the Ventricles—Anatomical Characters of Meningitis.—At No. 11, of the Salle St. Bernard, there is a woman, aged twenty-five years, who entered the hospital on the 25th of September, for an engorgement of the breasts during lactation. Her mammae were voluminous and hard; her pulse was frequent, and there was considerable heat of skin. On close examination you discovered something unnatural in her expression. Her manner was stupid, and before long she began to complain of intense headaches. Poultrices and a suitable diet dissipated the engorgement; the fever diminished, but the cephalalgia, of which she had complained from the beginning, still persisted, and Dr. Barth, who had charge of my service at the time, directed his attention to the brain. His treatment at first was simply expectant, as he had yet been unable to form any definite opinion of the exact nature of the disease. I shall now read to you the history and progress of the case since that time.

Oct. 18th. Cephalalgia; pupils dilated; increased stupor; answers slowly and without precision; slight delirium during the night. Up to this period the progress of the symptoms has been very slow.

Oct. 24th. Vomiting last night; skin dry and hot; slight delirium with chills; severe pain in the head; two stools; respiration accelerated; on sitting up to be ausculted complained bitterly and shrieked. The state of the lungs offers nothing of note. Leeches were applied to the mastoid processes, and an alum gargle ordered on account of a slight stomatitis, and sore throat, just appearing.

Oct. 26th. Salivation has occurred. Copious mucous secretions in cerebral disease may be regarded as rather a favorable occurrence, as they act as revulsives. Slight spitting of blood; slight alteration of expression; the chin seems drawn to one side; the tip of the tongue inclines a little to the left side; same stupid, dull air.

Oct. 27th. Salivation continues. Dr. Barth would not interfere for the reasons just mentioned. The patient is still heavy and stupid; the digestive functions are good; no involuntary dejections; she is more quiet than the preceding days.

Oct. 30th. Continued vomiting; sensibility of the limbs more and more dull; motion continues, but with considerable feebleness. Continual stupor, from which she can only be roused by severe pinching.

During the first days of November, the period at which I resumed the charge of the wards, there was double strabismus, and the right pupil was very much dilated. Emaciation proceeded very rapidly, and the patient fell into a collapsed and comatose condition, from which she was only aroused to give utterance to some vague and inarticulate expressions; habitu-

ally she remained in a complete state of immobility; the head thrown to one side, the eye haggard, with a completely besotted expression. The pulse became more and more small; the skin, particularly of the extremities, cold and of a purple hue; sensibility more and more obtuse, so that you might pinch her without causing any sensation. The vomiting ceased, but the stools became involuntary and continued. All the symptoms progressively increased, and the patient sank on the 24th November, about three o'clock in the afternoon.

Now the train of symptoms, continued Dr. Chomel, which this patient presented when I resumed the service, led me to infer a chronic cerebral affection, but I at first hesitated between a softening of the brain, a tumour, or a meningitis; but I inclined to the belief that it was the latter. The slight hemiplegia of the left side might, it is true, induce us to suspect the existence of a tumour in the right lobe of the brain, but it was at the same time very slight, and was rather a rigidity of the limbs, or muscular contraction, than genuine paralysis. It is besides very common to see these symptoms follow true meningitis, and they are not difficult to explain. I have had occasion to observe a large number of cases of acute meningitis, which offered us during life this marked difference in the degree of contractility of the two sides, and which revealed, on examination after death, the ordinary lesions of meningitis, with more or less serous effusion in the ventricles, without however any great difference in the pathological alterations of the two sides of the brain. It is very probable that the paralysis observed during life was produced by unequal compression, the serous effusion being more abundant on one side than the other. The paralysis, in fact, went on diminishing in proportion to the approach of death, or, to express it better, as the serous effusion became diffused over a larger portion of the cerebral substances, and the compression became, in consequence, more uniform; a species of general collapse succeeding to the hemiplegic contraction. This was the case with our patient, for the semi-paralysis which she experienced at the beginning of the disease successively diminished with its progress. The autopsy showed us the cerebral convolutions very much flattened, as if they had been long subjected to considerable compression. This aspect of the exterior of the brain enabled us to predict the existence of serous effusion in the ventricles. On opening the brain we found, in fact, four or five teaspoonfuls of serum in the two ventricles. The serum was yellow, transparent, and unmixed with any albuminous flocculi. The pia-mater was normal, and was readily detached; the arachnoid was sticky and adhered to the finger; the cerebral matter was firm, even more so than natural. There was no intracranial tumour. Thus in every point did the autopsy confirm our diagnosis.

With this case I will connect another which has some points of resemblance.

CASE II.—Partial Hemiplegia of left side.—Paralysis of the right superior lid, and of the motor muscles of the eye.—The consequence of repeated epileptic at-

tacks.—At No. 12, in the same ward, is a woman affected with incomplete paralysis of the left arm, with paralysis of the right superior eyelid, and of the internal, superior, and inferior recti muscles of the left eye, for the globe is in a constant state of forced abduction, and can execute no movement upwards, downwards, or inwards; it remains in a state of nearly immoveable diverging strabismus. Such was her condition on entering the hospital.

Let us now examine what can produce these phenomena. What is the disease in fact under which she is laboring? This woman says, that, for nearly three years she has been subject to epileptic fits. It is possible that she even had them before she was aware of the fact; we will, however, bear in mind, what she has told us concerning them. After the first attack she felt in all the left side a species of numbness, which by degrees disappeared, and sensation became natural. Since her infancy she had been subject to headache, which affected more particularly the right side. Other epileptic attacks followed, principally at the menstrual periods; they were preceded by no prodromes, seizing her suddenly, wherever she might be, without her being able to prevent or retard them. This latter circumstance is by no means unimportant, for it is one of the means of distinguishing epilepsy from hysteria. Hysterical women are, as every body knows, subject to epileptiform convulsions, but these convulsions are very different from those of our patient. Hysterical fits are never so sudden as those of epilepsy; they are to a certain extent subject to the will; while those of epilepsy are entirely beyond its influence. Hysterical women can, in a degree, control their attacks, and hence they rarely occur in the street, or in public places; indeed, they rarely have them, except when surrounded by those whose interest and sympathy they know will be excited. Hence, whenever you see a woman fall in the street in a fit, you may be assured that it is epilepsy and not an hysterical convulsion.

Let us return to our patient. Two or three months ago she was suddenly taken with one of these attacks in the street. During its access the extremities of the left side of the body became instantaneously paralyzed, and in this condition she was brought to the hospital. At the time of admission there was some diminution in the paralysis of the inferior member. She was unable to give any account of herself, as she remained immovable in bed, with nearly an entire loss of intelligence, and answering only vaguely and incoherently to questions, so that the degree of the paralysis of the limbs might be equivocal. The cessation of the paralysis in the limb, if real, was not of any great value in the diagnosis; for in cerebral affections of the same nature, the superior members sometimes are alone paralysed, whilst at other times the superior and inferior are equally affected. To complete the group of symptoms offered by this patient, let it be remembered that the mouth was inclined to the left side, that she screamed violently, and fell into a complete state of delirium, talking incessantly during the night, whilst during the day she was quiet enough.

What is the cerebral affection which can produce and maintain this train of phenomena? It can be readily conceived that a hemorrhage, for example, occurring on the side opposite to the existing lesions could, by compressing that side of the brain, produce the greater part of these symptoms. But a hemorrhage, as well as ramollissement, could only cause these symptoms once. When these convulsive movements, these epileptiform attacks occur fre-

quently at short intervals, you must seek some other cause of disease—a tumour for example. The most common organic cause of epilepsy are tumours of different kinds, situated in the cerebral mass. Hence it is in that direction that we must look for the exciting cause. If at the commencement of the disease there had been actual true paralysis, not followed by subsequent attacks, we could have admitted a cerebral hemorrhage; but we had an attack followed by a slight numbness and torpor in the members of the left side, then a return to a normal condition, and finally a last attack, producing the more marked and permanent symptoms that we now observe. This is precisely the ordinary progress of symptomatic epilepsy; that is to say, of that variety which is caused by a material organic alteration—a tumour, for example. Sometimes these cerebral tumours remain stationary, and then the consequent paralysis disappears gradually, to again reappear when the exciting cause makes fresh progress. It is thus that we are enabled to explain the intervals of quiet which patients suffering from this disease present, and of which the present case in particular offers a striking example. The time however arrives when the development of the disease is hastened, and a fatal termination soon follows.

The diagnosis of cerebral disease is always more doubtful than that of any other class of diseases—pulmonary affections for example; for the difficulty of diagnosis, in this case, is in proportion to the difficulty of exploring the diseased organ. We can only guide ourselves by the apparent symptoms, and the probable causes of the disease. Hence we are very far from being sure of the correctness of our diagnosis in the present case; but there is great probability that it is produced by a material alteration of the brain by a tumour located, from all appearances, in the right hemisphere.

The prognosis, as you may imagine, is very grave; the termination of the disease is not doubtful; it is irrevocably mortal; the exact period of its termination is only uncertain. The patient may live, or rather vegetate for some time; but sooner or later she must succumb. It is possible she will yet suffer from future attacks, in one of which she will die, or that softening will occur around the tumour, which disorganizing more or less the brain, will produce death.

As to treatment, there is none that is efficacious. The resources of art are reduced to palliatives and other means to retard the progress of the disease, such as setons behind the ear, mercurial frictions at the back of the neck, blisters and sinapisms on the extremities, purgatives, opiates, &c. &c. These are the only means that the materia medica places at our disposal to combat a similar disease.

Paris, Dec. 1842.

CASE OF EPILEPSY,

INDUCED BY A BLOW UPON THE HEAD, SUCCESSFULLY TREATED.

BY ISAAC PARRISH, M. D.

[Read before the Philadelphia Pathological Society.]

H. T——, the subject of the present note, is a young man of about 20 years of age, tall and of slim stature, and of strumous constitution, having been at one time affected with necrosis of the tibia, from which he had recovered, with the loss of several portions of bone.

While engaged in his occupation, as clerk of a

store, he had occasion to get upon a high counter, and in suddenly rising upon his feet, from a stooping position, struck his head with violence against the end of a gas-pipe, which projected from the ceiling. The blow was received upon the top of the head, two or three inches to the left of the sagittal suture.

He fell back in a state of insensibility, and, in a few moments, passed into a convulsion. A physician was immediately sent for, but when he arrived consciousness was returning; and nothing was prescribed in the way of medicine; the patient was cautioned, however, against undue exertion, &c. After the fit, severe headache continued, but the patient considered himself well enough to walk home, a distance of several squares.

On reaching the door of his chamber, in the third story, he uttered a loud scream, and fell prostrate on the floor in a violent convulsion. I was with him in a few minutes, while the attack was still upon him, and have seldom witnessed a more severe fit. The face was deeply flushed, head hot, eyes injected, pulse tense, with frothing at the mouth, and general muscular disturbance.

Iced water was freely poured over the head, and sinapisms were applied to the feet, and in a few minutes the attack subsided.

A large number of leeches were now applied to the temples, and the sinapisms were continued to different parts of the extremities, until the stupor following the convulsion had entirely passed away.

As consciousness returned, the pain in the head was still the subject of complaint; this, however, was greatly relieved by the leeching; the patient became calm and rational, and detailed with precision the particulars of the accident.

In about an hour, however, he broke out into incoherent conversation, screaming and laughing by turns, with hot head and flushed face; this quickly passed over under the use of cold applications, and he sank into a quiet, natural sleep. During this visit, the point of injury was carefully examined by shaving the head over the part, but nothing but a slight contusion could be discovered—the bone not appearing to be injured.

The accident occurred Seventh mo. (July) 31st, 1839, in the afternoon. During the night the patient slept calmly, but on the following day he had several attacks of severe headache, coming on suddenly, and attended with screaming, laughing, &c., as above described. During several of these, he was insensible for a few minutes; but was generally easy and tranquil in the intervals between them.

He took several doses of a decoction of senna and Sulph. Magnes. during the day, which purged him freely; the cold applications were continued to the head, and he was kept upon a low diet.

On the following day, Eighth mo. (August) 2d, the attacks were less frequent and severe, and in two or three days they subsided altogether. The patient was carefully excluded from all causes of excitement, being kept quiet in his chamber, and restricted in diet, until all headache and uneasiness had entirely left him, when he was allowed to go abroad cautiously, without, however, engaging in any business, and being restrained as far as possible from every thing which might excite his nervous system.

For a period of eight months the patient escaped a renewal of the disease; and it was hoped that he had entirely recovered from the predisposition. He suffered, however, from another attack in the Fourth mo., (April,) 1840. It came on during the exercise of singing at a place of worship; and, from what I could learn, resembled very much those which had

preceded it. From this time the susceptibility to the disease increased, and the attacks recurred at shorter intervals. Any sudden fright was apt to induce it; on several occasions the noise of the firemen and the ringing of the bells brought on a paroxysm. The patient was sent to the country with a view of improving his general health, and of separating him from those causes which seemed to excite his malady.

He remained out of town several weeks, during which time he was clear of the convulsions; on his return, however, they recurred, and were so frequent and distressing as to cause his friends great anxiety, and to render it unsafe for him to go abroad alone.

It was now remarked, by those who witnessed these attacks, that they were immediately preceded by a shoot of pain in that portion of the head which had been the seat of injury; the patient would seize his hair over this spot, and pull it forcibly, as if in agony, and then pass into a convulsion.

No pain in the head was complained of at any other time, nor did the patient seem aware that any connection existed between these attacks and the blow he had received. On close examination of the injured part, however, it was very evident that there was a sensitive point, although nothing externally indicated it. Pressure upon a spot about the size of a quarter of a dollar piece, a little to the left of the sagittal suture, caused severe pain and general nervous agitation, and indicated with sufficient clearness, the close connection between the convulsions and the injury which this part had sustained. This was evidently the point from which the *aura* arose, and at once assumed an important place in the subsequent treatment of the case.

A consultation was now requested, and that excellent and experienced surgeon, Dr. Thomas T. Hewson, joined me. After a careful review of the history of the case, it was determined to address our remedies chiefly to the original seat of injury; it was believed that the acute pain on pressure, and the evident suffering prior to a paroxysm, felt at this spot, furnished sufficient indications for such a course.

Eighth mo. (Aug.) 1st, 1840—just one year after the reception of the injury—assisted by Dr. Hewson, I made an incision, about two inches long, directly through the tender portion of the scalp, and down to the bone. Several issue peas were inserted between the edges of the wound, and secured in their places by plaster. In a few days purulent discharge took place, and a constant drain was thereby established from this irritated surface. A course of constitutional treatment, with tonics, salt bath, &c., was at the same time instituted, and we had the gratification of witnessing a rapid amendment in our patient; no return of pain or convulsions occurred, and his general health improved.

About a month after the incision into the scalp, the patient was attacked with severe periostitis in the limb which had previously been the subject of necrosis. Leeching, anodyne plasters, &c., relieved this affection in a degree.

At the end of seven weeks, the soreness in the scalp having entirely disappeared, it was deemed safe to remove the peas, and heal up the issue. A seton was passed over the tibia, which continued painful at times; this was kept discharging for several months, until all pain in this part had disappeared.

Our attendance upon the patient now ceased, although we did not consider him safe from a recurrence of the convulsions. He has, however, escaped entirely up to this time—a period of between two and

three years—thus giving us the opportunity of reporting his case as cured. When we consider the frequency of the attacks prior to the issue in the scalp, and the entire immunity from them since that time, notwithstanding the constant exposure of the patient to those causes which formerly induced them, we must regard this procedure as a highly interesting and important curative measure—at least in the present instance.

Remarks.—The great obscurity in which the pathology of Epilepsy is involved, and the inefficiency of all known medical means in its treatment, at least in the large proportion of cases, renders the report of every case, in which remedies have proved availing, a matter of some importance.

The case now presented offers an interesting example of that form of Epilepsy termed by the old writers, *sympathetic*, in which the brain appears to be involved secondarily—the paroxysm taking its rise from a point *without* the cranium. This variety has always been considered more manageable than that which has its origin in some hidden cause *within* the brain, whether induced by hereditary predisposition, or from a constitutional vice of any kind. Hence Hippocrates has sagaciously remarked that those epileptics are very hard to be cured “in whom the disease affords no sign from what part of the body it takes its origin;” and Celsus has said with equal propriety—“that if the whole body is affected at once, and no sense of the approaching fit is felt in any particular part, but the person falls down unexpectedly, of whatever age he is, he can hardly be cured.” Many similar expressions might be quoted from ancient authors, tending to show the importance which they attached to this distinction between diopathic and sympathetic epilepsy—a distinction which appears to have been too much overlooked by modern practitioners, except in cases where it is so obvious as to force itself upon our attention, as in fits occurring in infants from dentition, from indigestible matters in the alimentary canal, &c. Points of local irritation upon the surface of the body may be as influential in inducing an epileptic paroxysm, as internal causes, and, by removing them, we may be equally successful in putting a period to the disease.

Hence the importance of close inquiry into the history of each case, and if a centre or point be discovered, from which the aura epileptica takes its origin, our remedies may be directed to it with a hope of success. The application of blisters, issues, and even of the cautery to such diseased parts, are strongly recommended by the old authors, and many cases are reported in which they have been successful.

In some instances, the occurrence of a spontaneous discharge of matter from the head, the appearance of an eruption, or an accidental wound of the scalp, have accomplished a cure. Thus, we find in Van Swieten's Commentaries the case of a French nobleman related, who, being troubled with an epilepsy, took a journey into Italy, in order to consult the most skilful physicians there; but being plundered by robbers upon the road, and very much wounded, he was left for dead: besides other wounds, he had received a very large one in his forehead, which carried off a great part of the bone. After a long time he was cured of this wound; and at the same time was freed of the epilepsy, which used to return upon him every month.”*

The use of the trepan in certain cases of epilepsy,

following injuries of the head, was also recommended by the ancients—especially when the symptoms indicated disease of the bone, or the extravasation of humours under the skull, or pressure on the brain from a depressed fragment. This operation has been revived in this country by Dr. Dudley, of Lexington, who has reported several very interesting cases of cure after its performance. Dr. D. very judiciously restricts the resort to so serious a measure, to those cases only in which there is an evident depression of bone, or a morbid condition of it, produced by violence or other causes, leaving, thereby, but little doubt as to the point to which the instrument should be applied, and of the practicability of removing the cause upon which the cerebral excitement depends.

Dr. Dudley also believes that chronic inflammation of the pericranium is not an unfrequent result of contused wounds of the scalp, which have been healed too rapidly by the first intention; and that many unpleasant and alarming symptoms are the consequence of this practice.*

The case now narrated would seem to favour the idea, that chronic inflammation of the pericranium may even induce epilepsy, and that the establishment of a drain over the diseased surface affords the best means of relief.

Nor is it irrational to suppose, that the same practice might answer even in cases where the bone itself is diseased, without a resort to the trephine, provided the internal table were not involved in the mischief, and no pressure existed upon the brain.

Painful affections of particular nerves, coming on in paroxysms, and arising from disease in the trunk of the nerve, whether induced by injury or from other causes, are sometimes the cause of convulsions, which, if not arrested, may become habitual. Under these circumstances, division of the diseased trunk is obviously indicated, and has been long practised. A very curious case of this kind is related in the learned Commentaries just quoted: “A woman, thirty-eight years of age, had been twelve years subject to the epilepsy: in the beginning of the disease she had a paroxysm every month; afterwards it increased, that she suffered four or five strong fits every day, each of which lasted for an hour and upwards; whence, being rendered quite dull and stupid, she was no longer able to take care of her family. All kinds of remedies were used without the least success, the disease still growing worse.

In the mean time, the paroxysm always began in the leg, about the lower part of the gastrocnemii muscles; immediately it flew up to her head; and then she fell down violently convulsed, and foaming at the mouth.

A physician, who was present during the time of a paroxysm, compared the leg affected with the other, and he could not distinguish any difference between them: however, he boldly thrust in a scalpel, to the depth of about two inches, and in the bottom of the wound he found a hard, cartilaginous body, somewhat larger than a pea; he separated it from the muscles, and found that it rested upon a nerve: cutting the nerve, he laid hold of that heterogeneous body, and he pulled it out; this was no sooner done, but immediately the patient recovered out of the fit, saying she was very well, and afterwards lived quite free of this terrible disease, and recovered her former vigour both of mind and body.”†

* Van Swieten's Commentaries, vol. x, p. 425.

* Transylvania Journal of Medicine, vol. i.

† Van Swieten's Commentaries, vol. x, p. 438.

The facts thus hastily thrown together, sufficiently prove the position, that a small point of local irritation, which might readily escape notice, may prove the source of this terrible disease, and that it becomes the physician to investigate closely the history of each case.

That many cases of idiopathic epilepsy occur, which are entirely beyond all known means of cure, is lamentably true; while it is possible that cases deemed hopeless might be relieved, were physicians more accurate in scrutinizing them.

It may be remarked, in addition, that the practice of making an incision through the scalp over the sagittal suture, and of inserting the issue peas, with a view of establishing steady counter-irritation in this situation, has been employed for some years past by Dr. Charles Evans in the treatment of chronic affections of the brain, with very satisfactory results. The extensive opportunities enjoyed by Dr. Evans for observation on these diseases, as physician of a large insane hospital, renders his experience upon the question very valuable.

[The following note was intended to accompany Prof. Horner's case of luxation of the cervical vertebræ, published in the last number of the Examiner.]

Dr. Schuto, of Vienna, reported a case in the *Medizinische Jahrbuch des Österreichischen Staates*, for 1840, of a case of dislocation of the cervical vertebræ, which terminated favorably. A young man of twenty-four years, twisting suddenly his head, felt something give way in his neck, and the head remained immovable. The next day his face was swollen, his head turned to the right, and bent towards the shoulder. His neck was arched slightly to the left side, but hollowed on the right. He complained of pain, which pressure on the third, fourth, and fifth cervical vertebræ increased. The head was perfectly immovable; any attempt at motion was followed by great pain. The spinous processes of these vertebræ could not be traced. There was some feebleness of the right arm, and it required some effort to lift it. No other symptoms existed. An attempt at reduction, by lifting up the head, the trunk being fixed, failed. On the third day the numbness in the arm increased somewhat, and a further effort at reduction was made, and successfully. The patient being laid on the floor, the shoulders were fixed by folded sheets, a towel was passed under the chin, and the occiput was supported by both hands of an assistant: extension was then gradually made, until both patient and assistant experienced a snap, as of two bones meeting. On gradual relaxation of the extending force, the head was found in its natural position, and the power of motion was restored. On the next day there was rather more numbness, with some vertigo, and a quick pulse. Bleeding relieved all these unpleasant symptoms, and on the ninth day he left the hospital perfectly cured.—ED. MED. EX.

A DRUNKEN POPULATION GETTING SHORTER.

In the department of Finisterre (Brittany,) the use of ardent spirits seems to increase, and to be attended with some peculiar effects on the population. In the two arrondissements of Quimper and Quimperlé, the spirituous liquors imported increased from 1,869 hectolitres in 1825, to 3,985 in 1839; and, corresponding with this increase, the average stature of young persons subject to military service is said to have diminished until it had become 23 millimetres (about an inch) less in 1838 than in 1818.

CLINICAL LECTURES AND REPORTS.

UNIVERSITY OF PENNSYLVANIA.

CLINIC OF DR. W. POYNTELL JOHNSTON.

At the Locust Street Dispensary, Jan. 14, 1843.

[Reported from notes by Henry Sargeant.]

LECTURE I.

(Concluded.)

CASE IV.—*Lacrymal tumour—Operation—Occlusion of the nasal duct—Obliteration of the lower portion of the lacrymal sac—Great epiphora—Perforation of the os unguis—Cure.*—The patient now presented to you, gentlemen, Eliza Roberts, aged 25, of a lymphatic temperature, at the age of 15 was operated upon in England for a lacrymal tumour of the left eye. An incision was made into the lacrymal sac, and an effort made to pass a style into the nasal duct, this attempt proved unsuccessful and the disease was left to itself—the position of the cicatrix will show you how impossible it was for this operation to have succeeded. The incision was made too near the floor of the orbit. The introduction of a style into the nasal duct, through an opening in this situation would be impracticable. Since the operation the epiphora has greatly increased, but there has been no return of the lacrymal tumour. The eye was so constantly suffused with tears, that when she first presented herself at the clinic, five weeks since, you may recollect that she could neither read nor sew—her whole employment consisted in mopping the eye with her handkerchief. We endeavoured to introduce an instrument from the nose into the lacrymal sac, it passed as far as the floor of the orbit, and was there invincibly arrested. A probe was passed through each of the puncta lacrymalia, and through each reached the upper portion of the sac, where it was arrested. Water thrown by a syringe into the lower punctum, was ejected in a jet by the upper one. From these facts we concluded that the puncta and ducts, although smaller than usual, were not obliterated—that they opened into a remnant of the sac, although this remnant appeared to be smaller—and that it was necessary, in order to relieve the distressing infirmity under which the patient was suffering, either to re-establish the natural route of the tears, or to open a new channel of communication with the nose. We decided, therefore, to open the remains of the sac, if such could be found, and to endeavour to pass an instrument through the nasal duct; if this attempt failed, as we anticipated, the operation would be concluded by the formation of an artificial passage. We pointed out to you the various operations which have been suggested for this purpose, and decided in favour of a perforation of the os unguis.

The tendon of the orbicularis was rendered tense by drawing the muscle outwards—the tendon was carried slightly backwards by the flat surface of a straight bistourie, which was then plunged into the sac, and directed towards the nasal duct—the point did not penetrate into the duct—the bistouri was then withdrawn in such a way as to enlarge the incision in a direction parallel to the straight tendon.

Upon introducing a probe it was found, as was expected, that only the upper portion of the sac remained, into which the lacrymal canals opened; an ineffectual effort was again made to pass an instrument into the nasal duct. A plaque of horn, such

as was employed by Mr. Hunter and Dr. Physick, in fact, the identical one used by Dr. Physick, was then introduced through the nostril, as a point d'appui, and the os unguis being fairly exposed, an effort was made to remove a circular piece from it by means of a punch. It was found, however, that owing to the projection of the process of the upper maxilla, the punch could not be made to act perpendicularly upon the bone. The plaque of horn was consequently removed, and the os unguis was perforated by a drill, shaped like a cobbler's awl and so managed as not to pierce the bone but to remove a circular piece by attrition. The wound was kept open for twenty-four hours by the introduction of charpie, and a style was then passed into the artificial opening in the bone; the epiphora was at once relieved, the patient was found reading on the third day, without inconvenience; the general health rapidly improved; the redness and puffiness of the lower lid, which caused so much deformity, disappeared; and she represents herself as entirely cured. We should be wrong, however, in offering this case as one of complete cure. She can read, sew, and attend to all the ordinary duties of life without the least inconvenience, and without any appearance of epiphora, but upon exposure to air, or to a strong light, or to the heat of the fire, the eye again becomes slightly suffused with tears. How shall we account for this? The tears pass freely into the nose from the remaining portion of the sac, the nostril is as moist as that on the opposite side, but we have already mentioned that the lacrymal puncta and ducts were themselves diminished in calibre. We will again examine their condition. The instrument employed is, as you perceive, not the probe of Anal, but an inflexible probe of steel, for which I am indebted to Professor Horner, which is fitted to a handle, similar to the handles generally adapted to eye instruments. An instrument of this kind possesses real advantages over the ordinary probe—the surgeon is not only certain of the position and direction of the point of his probe, (of which he cannot be with a delicate and very flexible instrument) but he is able to manipulate with such a handle with greater security—the objections which may be urged against the employment of an inflexible instrument from the injury it may inflict, attach of course to the want of anatomical knowledge or want of skill of the operator, and not to the operation itself.

This small inflexible probe when introduced into the lower punctum passes readily to the sac, but at the moment of entering the sac it appears to encounter an obstacle. Each time that it is withdrawn and reintroduced we meet with the same difficulty; there is clearly at this point an obstruction, apparently a valvular fold of the mucous membrane. The introduction of the instrument is unattended by pain. In attempting to probe the upper duct, you perceive that this instrument is arrested at the punctum, which is much smaller than natural, we are compelled to employ the finest probe of Anal, which you perceive passes into the sac without the slightest difficulty. We have here a contraction of both the canals by which the tears are conveyed to the sac. Between the sac and nostril, a free communication has been established by an operation; this is shown by the fact that the left nostril is as moist as the right, and that the epiphora, from which she suffered so much, has entirely disappeared. The lacrymal ducts then have a sufficient calibre to convey to the sac the ordinary amount of tears secreted during the repose of the organ, and from the sac these tears pass freely into the nose, but when owing to any excitement

the amount of tears becomes greatly augmented, the whole of the fluid cannot be transmitted through the contracted duct to the sac, and the excess exhibits itself as epiphora.

The cure in this case then is not complete—it is not sufficient to open a communication between the sac and the nostril, we must see that the channels by which the tears are conveyed to the sac are free also, and possess their natural calibre. The treatment will be continued by the introduction of probes, to dilate these canals, augmenting gradually the size of the probe, until the dilatation is complete.

CASE V.—Syphilis three years since—Great exposure during a whaling voyage—Caries of the upper maxilla.—This young man contracted a chancre just prior to a whaling voyage, for which he shipped three years since. During the voyage he was treated by his shipmates, and took various preparations containing mercury, which were found in the medicine chest. The chancre became indurated, and finally healed, leaving an induration behind it. During the voyage he was much exposed in open boats, and, upon the return passage, suffered greatly from a swelled face. Upon his arrival he presented himself at the clinic. His appearance was then cachectic; his strength prostrated; his appetite gone, and digestion impaired. The face was enormously swollen; the mouth could with difficulty be opened; the fetor of the breath was extreme; the gums, in a spongy condition, bled profusely on the slightest touch; a fistula existed at the internal canthus of the left eye, from which mucus and tears could be forced. A probe introduced into this, encountered a small scale of denuded bone. On forcing the finger into the mouth, a large piece of dead bone could be felt projecting into the mouth; this was removed, and proved to be a portion of the tuberosity of the maxilla, about an inch in length, in a carious condition. The hæmorrhage which followed the removal of this fragment was alarming from its quantity; it could only be arrested by tamponing the cavity from which it was removed, with charpie impregnated with the muriated tincture of iron. The patient was at once placed upon the iodide of potassium, of which he took twenty grains daily in a half-pint of hep-tea, for two weeks. At the end of this time, a great improvement had taken place: the fistula lacrymalis had healed entirely; the swelling of the face had disappeared; the colour, appetite and strength had returned; the sponginess of the gums had diminished; in a word, all the symptoms had been ameliorated. He was directed to continue the iodide of potassium, and he now informs us that his health since that period has been entirely maintained. He presents himself to-day, complaining of a fetid discharge from the left nostril. On introducing an instrument we encounter a fragment of denuded bone; you can hear the click of the instrument against it. You perceive that the various forceps we employ slip off from it; it does not project sufficiently to be grasped. We have at length seized it with a small pair of Gibson's bullet-forceps. Upon making traction, a depression is produced at the internal canthus of the eye; the tears flow over the cheek, and the patient complains of great pain in the infra orbital nerve. It is too firmly attached to be drawn away without great violence.

This is clearly a case of caries of the upper jaw, following syphilis—a syphilis which has become constitutional, as exhibited by the persisting induration, &c.—a syphilis which, in its primary form, was treated by a free, if not injudicious, use of mercury. Time will not permit us, on this occasion, to ex-

amine
this
disea
Is it
minis
conjo
mome
the bo
that v
study
import
to con
with a
cavity
as the
requir
might
fra-or
mit n
thorou
health
be los
genera
so rap

S.
hops;
powde
wine-
three

CAS
of low
of the
the op
—Eliz
ment,
enjoy
molar
about
lowed
less in
a large
from v
at first
chin, a
spot a
the cu
ed by
the p
ever,
ble u
so gre
of the
vous,
of a re
from b
has be
cess,
These
prostr
timid
opene
fetid;
side of
an ex
You p
tooth f
suffici
of bon

amine some very interesting questions connected with this case. We can merely allude to them: Is this disease of the bone a simple consequence of chancre? Is it simply caused by the mercury which was administered? or is it the result of these two influences conjoined? To these questions we cannot, for the moment, enter upon a reply. Similar affections of the bones are, however, so frequently presented here, that we can scarcely fail of another opportunity of studying this subject, which is practically of great importance. The remaining carious fragments appear to consist of the nasal process of the upper maxilla, with a portion of the orbital plate, and to involve the cavity for the lodgement of the lacrymal sac, as well as the infra-orbital canal. Great violence would be required to detach it at present, and this violence might cause some injury to the lacrymal sac and infra-orbital nerve. It will be better, therefore, to permit nature to separate the diseased bone more thoroughly before attempting its removal. As the health of the patient is improving daily, nothing will be lost by the delay of a week or two. The same general treatment, under which he at first improved so rapidly, will be resumed.

R. Potass. Iodidi, ℥iv,
In. Chart. No. iv. Die.

R. Humuli Lupuli, ℥ij.
In. Chart. No. iv. Die.

S. Make half a pint of hop-tea with each paper of hops; strain the tea; add and dissolve in it one of the powders of iodide of potassium, and administer a wine-glassfull every 6 hours. Repeat this during the three succeeding days.

CASE VI.—*Extraction of second large molar tooth of lower jaw followed by great swelling, and necrosis of the alveolar processes—Abscess near the chin—through the opening, the ramus of the jaw can be felt denuded.*

—Elizabeth Barker, æt. 26, of lymphatic temperament, and great nervous irritability; otherwise in the enjoyment of good general health, had the second molar tooth of the left side of the lower jaw extracted about three months since. The extraction was followed by violent pain, which has continued, although less in degree, ever since. In the course of a week, a large swelling was perceived opposite the point from which the tooth was extracted. This swelling, at first entirely hard, gradually advanced towards the chin, and become more so; finally a red fluctuating spot appeared beneath the ramus of the jaw, opposite the cuspid tooth of the lower side. This was opened by her physician, Dr. Page, with great relief to the patient. The swelling still occupies, however, the whole ramus of the jaw, and is sensible upon pressure. But the sensibility, is not so great as you might suppose from the shrinking of the patient. She is nervous to an extreme—nervous, not only because of the existence and duration of a real pain, but because the swelling prevents her from being properly nourished, and because the pain has been alleviated, prior to the formation of an abscess, by the continual administration of laudanum. These combined causes have produced a nervous prostration, which renders the patient remarkably timid and apprehensive. The mouth can only be opened to a moderate extent; the breath is extremely fetid; the finger introduced feels distinctly on the inside of the cavity, from which the tooth was removed, an exposed mass of bone, which is moveable.

You perceive that it is easily extracted with a pair of tooth forceps, now that the patient has summoned up sufficient courage to open her mouth. The portion of bone removed, in length about an inch and a half,

consists of the inner margin of apparently three alveolar processes. When we introduce a probe into the opening of the abscess, near the chin, it encounters at once a denuded bone, and can be directed backwards along this denuded bone, on the inner side of the ramus of the jaw, until its point can be felt by the finger, introduced into the mouth, opposite to the gap left by the removal of the dead alveolar process. It is arrested, however, by the mylohyoid muscle, and does not penetrate the mouth.

This denuded portion of bone is not moveable; the line of the teeth remains unbroken. Consequently, it cannot be regarded as a fragment detached from the bone and necrosed, as was the case with the fragment which we have removed. We must consider it as a mere exposed surface of bone—exposed by an abscess—which abscess, originating in an injury to the bone itself, has fused down in contact with the bone. A slight exfoliation may occur from this, after which granulations will appear and organize, and the cure will probably be completed without further recourse to instruments.

This case contrasts completely with the last presented. In the one, a general cause produced a morbid action in the upper jaw, terminating in caries; in the other, a local injury detached a fragment of the lower jaw, which in consequence was deprived of vitality, died, was necrosed; while an abscess, in contact with a remaining portion of the bone, separated the periosteum, cut off from the surface the proper supply of blood through the periosteal vessels, and also terminated in necrosis—the necrosis of merely the surface of the ramus of the jaw.

JEFFERSON MEDICAL COLLEGE.

CLINIC OF PROFESSOR MÜTTER.

Dispensary of Jefferson Medical College, Jan. 11, 1843.

(Reported by H. T. Child.)

CASE I.—*Ulcer of the lid, of seven years standing—cause unknown—Blepharoplasty operation for its relief—results of operation.*—Professor Müller commenced the lecture of this morning by exhibiting the results of a very extensive blepharoplasty operation, performed before the class about five weeks since. This patient was a woman, aged about 40, who, for several years had suffered from a chronic ulcer, partaking somewhat of the nature of lupus, but involving the integument only, and which occupied nearly the whole of the lower lid of the left side. All the usual remedies having failed to cure the disease it was determined to perform the operation alluded to above.

The object being to remove the whole of the diseased tissue and substitute for it a flap of healthy skin, the operation was commenced by making an incision, starting from the inner canthus, and continued downwards and outwards, until it ceased about an inch and a half below the inferior orbital ridge; another incision was then carried from the external canthus downwards and forwards, to meet the first; the whole of the diseased mass was thus included between the two, and then immediately dissected out, leaving a space of the shape of the letter V.

The oozing of the blood having in a great measure ceased, and the parts being carefully examined, in order to prevent the least particle of the diseased tissue being left behind, the second step of the operation was commenced. Starting from the superior extremity of the external incision, the bistoury was made to take a course, at first upwards for about six

lines, and then outwards for an inch and a quarter, the latter being curvilinear, in order that the upper margin of the flap might correspond in shape to the natural curve of the eyelid. (See fig. 1.)



From the terminal extremity of the incision another was carried downwards and forwards, until it reached a point opposite the union of the two first. The flap included in these incisions was then dissected up, brought over the raw surface from which the diseased tissue had been removed, and attached to the sound skin by two twisted and two interrupted sutures. (Fig. 2.) The surface from which it had been removed was then closed, by drawing the edges of the wound together by the twisted suture and straps. A compress was then applied over the flap and secured with a roller, firmly applied, so as to prevent by pressure, the oozing of blood, which, in all operations of this kind, is one of the chief obstacles to union by the first intention. The patient was then ordered to be kept quiet, the compress to be saturated with cold water; the head to be maintained in an elevated position, and the diet to be absolute.

Nothing of interest occurred in the subsequent treatment, and in about two weeks the patient was perfectly cured, union by the first intention having taken place throughout. The surface from which the flap had been taken, united in the same way with the exception of a small space a few lines in diameter, which healed by granulation.

The appearance of the patient is greatly improved, and the operation may be considered as perfectly successful.

Professor Mütter remarked that many surgeons had no confidence in plastic surgery, from the fact that the flap generally shrinks, and in consequence of this the patient is often as much deformed as before he submitted to the operation. But from very ample experience he was able to state that this result was to be attributed, rather to the surgeon than to the operation, for if the flaps are made large, much larger than would seem necessary at the time, when contraction takes place, there is enough tissue to spare, and at the same time to cover in completely the parts upon which it has been applied.

No operation of this class is more deserving our confidence than Blepharoplasty, (from *βλέφαρον*, the eyelid, and *πλαστική*,) especially when the lower lid is the seat of the disease; in affections of the upper lid its results are less satisfactory.

The deformities and diseases of the lids requiring the performance of this operation, are ectropium, entropium, ulcerative degeneration, destruction of the organ, and its transformation into innodular tissue, so often met with as a result of severe burns or scalds of the face. In the older works which treat of plastic surgery, this particular operation is not mentioned, and even Celsus lays it down as an axiom that a lid once lost cannot be restored: "*Si pelpebra tota*

deest nulla id curatio restitue potest." It was first performed in 1816 by Græfe. The complex organization and delicacy of the tissue to be restored, render blepharoplasty an operation of great interest and difficulty, and it is impossible, as Zeis well observes, to produce an artificial lid from the common integuments which shall possess mucous membrane, muscle, glands, ciliæ, cellular tissue, &c. &c., but we can imitate nature very closely, in the form of the protection, which it is our object to supply to the tender organ that has been deprived of its natural covering.

It is really surprising how much, in this respect, can be done, and the case before us is a good illustration of this fact, for it is almost impossible to say on which eye the operation has been performed.

The surface of the flap next to the ball has been converted into a tissue similar, in most respects, to mucous membrane; no adhesions exist between it and the ball, and hence the movements of the latter are free—the tears pass into the punctum lacrymale as usual, and the margin of the flap is rounded off so as to resemble a natural lid.

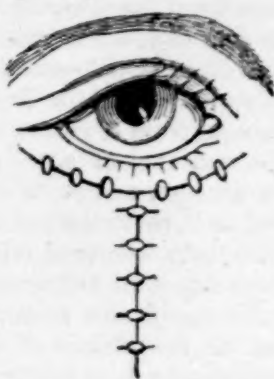
Various plans have been adopted to carry into effect the object of the surgeon, but it must be obvious that no one method is appropriate to every case, nor will it be proper to attempt the execution of any plastic operation, unless there exists in the vicinity of the eye, an abundant supply of healthy integument and subcutaneous cellular tissue.

In cases of simple eversion of the lid from any cause not malignant, Dzondi proposed to "divide the cicatrix and allow it to heal by granulation, so that the broader scar might remedy the defect." A very strong objection to this operation at once presents itself in the fact that the incision, in healing will contract, and may in consequence, of this, increase the deformity. Nor is the operation of Sir William Adams, the one chiefly in vogue, applicable to any other cases than those in which there exists simple eversion of the lid, without much alteration in its structure, and wherever the entire organ is to be restored nothing short of plastic surgery will prove of the least utility.

The operation of Dieffenbach for ectropium of the lower lid is much more to be relied on. He removes the cicatrix by an incision of a triangular shape, the basis of which is towards the ciliary margin, and the apex downwards; he next divides the integuments laterally, the incision being curvilinear, then cuts out the diseased tissue, and finally raises the lateral portions forming the sides of the triangle; the cuts margins are then brought together, and united by suture. (Fig. 3 and 4.)



3



4

The operation of Fricke, of Hamburg, for making a lid has many advocates, among whom are Jünghen, Blanden, Gerdy, Jobert, Carron, Liston, Warren, and, I believe, Kearney, Rodgers, and Post, of New York; and is undoubtedly an operation to be relied upon in many cases, although my own experience with it leads me to prefer another plan. This operation consists in cutting away the diseased mass, or dividing the lid, so that its ciliary margin may be separated from the lower portion, and thus leave a space between them. Into this space, or upon the raw surface, where the whole lid is removed, a flap of integument of the proper shape and size, taken from the temple, is then placed, and attached by sutures to the edges of the wound.

The objection to this method is, the necessity always existing for *torsion* of the *pedicle* of the flap, by which the probability of union is much diminished, and the danger of sloughing from a want of blood increased.

Another method of operating has been proposed by Dieffenbach, which deserves our highest confidence, and must undoubtedly become the favourite operation of every one where the case admits of its being carried into execution. It has already been repeated by Professor Ammon of Dresden, Zeis, Von Ekstrom, Fricke, Peters, Lawrence, Tyrrell, and others, and is the one performed in the case now presented, which makes the third in my own practice.

The advantages of this method, which belongs to plastic operations by "*inclination of the flap*," are, the facility with which it is executed, the little risk of sloughing from the pedicle of the flap being scarcely, if at all, subjected to torsion, and the trifling scar which it leaves.

Professor Jaeger, of Berlin, has proposed a plan of operating that may do very well in some cases, and therefore I will explain it to you.

The operation belongs to the class of plastic operations by "*sliding the flap*," (*glissement du lambeau*), and is peculiarly adapted to cases of lagophthalmos and ectropium. It consists in first cutting through the everted or shortened lid in its whole thickness by a transverse incision, including its whole breadth; he then cuts out a perpendicular piece, so as to bring the lid to its proper width; he next loosens the integuments of the cheek, if he is operating upon the lower lid, or of the forehead if the upper is the seat of disease, with a double edged knife carried between the orbicularis muscle and the bone, so that they can be drawn upwards or downwards to a sufficient extent. The wounds are then united by sutures. A method somewhat similar to this has been proposed by T. W. Jones, of England. He includes the cicatrix or contracted portion in two incisions, which unite at an

acute angle, so as to form a V, and must extend into sound tissue. He then draws upon the flap, so as to stretch out the cellular tissue beneath it, and when this does not yield readily, he dissects up a portion of the flap; and, by thus sliding the skin, he expects to gain the object in view. This operation might possibly answer in some cases, but I do not recommend it as we have other means more worthy of confidence, and it could rarely, if ever, be performed where it is necessary to form the entire lid.

Professor Horner has recently performed an operation for ectropium, which differs a little from the operations mentioned, but belongs to the class of operations by "*displacement of the flap*."

Professor Pancoast has recently reported two cases of blepheroplastic operation, in which he combined the methods of Dieffenbach, Sir William Adams, and Jones, and in both cases his success was complete.

(To be continued.)

PHILADELPHIA HOSPITAL.

PROFESSOR PANCOAST'S CLINIC.

January 14, 1843.

[Reported by J. P. Tabb, Resident Surgeon.]

(Concluded.)

CASE IV.—The lecturer next exhibited a man with chronic enlargement of the tonsil gland of each side; and remarked, that in this case, though from the size of the tumours there was much inconvenience felt in deglutition, with stertorous breathing in his sleep, and sense of strangling, that occasionally waked him up; still it was not from either of these causes that the patient was desirous to have them removed, so much as the constant tendency of these swollen and spongy tumours to give rise to an attack of quinsy, on every exposure to cold. In the forming state of such tumours, and especially in scrofulous children, he had found astringent applications, and touching with lunar caustic, to cause them to disappear; but in general, when fully formed, he preferred excision as being more speedy, certain, and not dangerous. In former times surgeons were in the habit of removing them by a canula and wire ligature, strangulating the tumours at their base, which afterwards sloughed off. This plan was painful, tedious, uncleanly, and even dangerous.

The European surgeons, in excision of these parts, usually employ a hook or toothed forceps to seize the part, and remove it with the scissors or bistoury. The only instruments really well suited to this operation are of American invention. The ones which

the lecturer commonly used were the guillotine instrument of Physick, as modified by Dr. J. K. Mitchell; the ring instrument of Fahnestock, with a knife nearly circular in shape; and a modification of this, with a pair of forceps and spring upon the front, which of itself draws out the tumour from between the half arches, so as to insure the removal of a sufficiently large portion. To the latter instrument he was inclined to give the preference, as it required but the use of one hand. A tonsil was then removed without difficulty by each of the two latter instruments; which, as the edge of the knife could not from its shape be made quite so keen as the chisel of the guillotine instrument, he thought was less likely to be followed by troublesome bleeding. No instrument is usually necessary to hold down the tongue. All the precaution necessary in the operation is to accustom the fauces to the contact of instruments, by frequently touching them for several days previous with the handle of a spoon; and to be careful not to incise the half arches, which, as shown by Dr. I. Parrish, might be followed by some difficulty in enunciation.

CASE V.—was a fracture of the clavicle just beyond the middle, presenting the usual deformity of the shoulder following the injury. The accident was of 11 days standing. Dessault's bandage had been applied, which had not answered well, the fault being rather with the patient, who was exceedingly restless. The apparatus of Dr. Fox was shown and applied, which Dr. P. preferred in the treatment of this injury to Dessault's, as fulfilling the indications of treatment equally well, being less liable to derangement, and leaving the patient more at ease. The injury had occurred by a fall from a second story window, upon the elbow and trochanter major of the left side; the whole region of the hip having sustained a violent contusion, as shown by the extensive effusion of blood below the skin. He took occasion to call the attention of the class to the influence of the age of patients in modifying such accidents about the hip. For a fracture of the neck of the thigh-bone would most likely have been produced in addition, if the patient had been advanced in life. He had found this result often produced in this way, and occasionally seen the fragment of bone so interlocked by the force of the blow, as to maintain a straight position of the foot for several days after the accident. In the present case, though there was neither fracture nor displacement, some indistinct crepitation was heard on rotation of the limb, perceptible to the patient, and which he called slipping of the bone out of its place; but which was attributable merely to the friction of the trochanter against the thickened and inflamed cellular tissue of the part.

CASE VI.—Was a severe case of frost-bite of both hands, which having occurred at sea, had been improperly treated. The specific character of the affection was now lost; the sloughs were beginning to separate, and required nothing more than the ordinary treatment for chronic ulcers, poultices, till the sloughs were discharged, and slightly stimulating applications afterwards, attention being given to keep the fingers separate, and prevent adhesions between them.

CASE VII.—*Operation for Hydrocele.*—This was an accumulation of fluid in the tunica vaginalis testis, that had accompanied a chronic enlargement of the testicle, and remained after the latter had been completely discussed by treatment. The case having before come under the notice of the class, and the

lecturer having on the occasion of a former operation entered fully into the nature of hydrocele and its treatment, he at once injected the sac with a fluid consisting of one part of Tr. of Iodine and three of water; a measure of proceeding which had been invariably successful in his hands.

CASE VIII.—*Amputation of the toe, at the metatarsophalangeal joint.* This was a case of dislocation of the small toes of long standing, resulting from a fall of some bricks from a height on the dorsum of the foot. The points of the toes were directed outwards to the margin of the foot. The small toe had been removed by the lecturer a year ago, in consequence of its preventing the wearing of a shoe, by its projection beyond the margin of the foot. Attention was called to the covering of the stump, which was soft and moveable, a result which is obtained only when we operate upon either margin of the foot, by giving the greatest length possible to the outer flap, as there is a disposition to the retraction of the marginal integuments, and the exposure of the end of the metatarsal bone. A similar degree of inconvenience as the first is now experienced from the second small toe. This was removed by the oval operation, commencing it at the top of the joint and circumscribing in the first incision the commissure of the toes. To this operation the lecturer gave a decided preference over that of Lisfranc, which divides the thickened and sensitive covering of the sole of the foot, and is apt to leave a painful cicatrix. No dressing was required but a single strip of adhesive plaster to close the V shaped wound that was left on the removal of the toe.

WILLS' HOSPITAL.

CLINIC OF DR. ISAAC PARRISH.

[Reported by George H. Burwell, Resident Physician.]

Wednesday, Jan. 11, 1843.

Sarah Porter, aged about 20 years, presented herself for advice on account of an encysted tumour of the upper eyelid, near the external canthus—of two years standing.

The tumour was moveable under the skin; and on everting the lid, its base could be distinctly defined, adhering to the tarsal cartilage. It had been for a long time stationary, and caused no pain; but the patient was exceedingly anxious for its removal, on account of the deformity and inconvenience which it produced.

Dr. Parrish remarked, that these morbid growths were very common, particularly in young persons of a strumous constitution, several sometimes occurring at one time, in the same individual, and causing no little uneasiness to anxious friends. They were, however, innocent in their character, and frequently disappeared spontaneously, or under the influence of a mild alterative course, and without any local application. It was better, therefore, not to be in haste about removing them, especially in young persons, but rather to rely upon constitutional means to correct the morbid condition of the system under which they originate. If, however, they have persisted for a long period, it may become necessary to remove them.

There are two methods whereby this may be accomplished. First, by external incision through the integuments and orbicularis muscle; and, secondly, by puncture through the cartilage. The former me-

thod is that most generally adopted; but if the cyst be imperfect, as is often the case, or if adherent to the tarsal cartilage, as in the present instance, it could not be removed entire, and hence the cure would be incomplete without further treatment. In this case we shall therefore adopt the latter method, and rely upon gentle stimulation of the surface of the sac, after its contents are discharged, for the perfection of the cure.

The lid was now everted, and a small incision made with a scalpel, into the sac—by slight pressure a quantity of matter about the consistence of thick cream escaped, and the tumour subsided: a plug of lint was pushed through the opening into the sac, and allowed to remain. The patient presented herself at the next prescribing day; when a small piece of the sulph. cupri was introduced into the sac, and its surface lightly cauterized.

January 21. She again returned; the sides of the sac had closed, and the wound by which it was opened entirely healed up. Discharged cured.

The next case, to which we have to direct your notice, is that of Catharine Callahan, aged 37. Early in the summer of 1841, she unfortunately got a piece of quick lime into the right eye, which was of course followed by severe inflammation—which was treated, as she tells you, by the usual antiphlogistic remedies. In about six months the left eye became sore, and soon after this, or in December, 1841, she was admitted into the hospital by our colleague, Dr. Hays, for ophthalmia, ulcers, and opacity of the cornea, and came under our care when we took charge of the house, on the first of January, 1842. Under the usual treatment, she had so far improved by the April following, that her husband requested her discharge, although she was not well. Her sight remained pretty good for a month after she left, when a renewed inflammation of both eyes occurred, followed in a short time by such an opacity of the cornea, that she could not make her way about. In this condition she remained all summer until the 7th of September, when she again applied for admittance into the hospital. The improvement was then rapid for about three months, but since the middle of December it has been more slow. The sight of the right eye, which first became inflamed, is now the best—that of the left eye is very defective, the treatment not having had so beneficial an effect upon it as upon the other. When admitted in September, besides the opaque cornea, the upper lids of both eyes were covered with granulations. These, as you see, have been removed, and both lids now present very nearly a healthy appearance.

The opacity of the cornea has persisted for so long a period, that the ordinary remedies have ceased to exert a perceptible influence over it; or, at least, the improvement is so slow, as to induce us to make an effort to hasten it.

It is the result originally of an attack of conjunctivitis, in which the cornea has become involved secondarily.

The thickened state of the conjunctiva covering the globe of the eye is very evident, and you see a number of enlarged varicose vessels traversing it, and passing in upon the cornea. Now the object of our treatment is, to diminish the calibre of these vessels, and cut off the undue supply of blood which feeds this opaque portion of the cornea. This we can generally accomplish by astringent washes drop-

ped upon the eye, and persevered in for a long time, or when the lids are granular, by the application of sulph. cupri to the granulations; but sometimes the structure of the conjunctiva has become so far altered, as to render this treatment ineffectual, without a resort to some other means.

A plan, which we have frequently adopted in this house, with marked advantage is, to clip out a small fold of the conjunctiva, in which one or more of these enlarged vessels are included, and thus to prevent the farther passage of blood in that direction. This is done by separating the lids, and requesting the patient to turn the eye in the desired direction, when the operator carefully seizes a fold of the conjunctiva with a small sharp hook made for the purpose, passes a pair of sharp curved eye-scissors behind it, and clips it off. A very small piece is generally sufficient, and this should be taken in most instances from the upper half of the eye, near the edge of the cornea, as the vessels are most numerous in this situation, originating, as they generally do, from the conjunctiva lining the upper lid. In performing this operation, care must be taken not to lacerate the membrane, or wound the sclerotic; nor should we attempt too much at once: it is better to clip out one piece at a time, and repeat the operation if necessary.

A small piece of the conjunctiva, just above the superior edge of the cornea, was now seized with the hook, and cut off—and the patient was advised to encourage the bleeding which followed by the application of warm water.

BIBLIOGRAPHICAL NOTICE.

A system of Anatomy, for the use of Students of Medicine. By CASPAR WISTAR, M. D., late Professor of Anatomy in the University of Pennsylvania. *With Notes and Additions.* By W. E. HORNER, M. D., Professor of Anatomy in the University of Pennsylvania. Eighth Edition. Entirely remodelled, and Illustrated with more than two hundred engravings. By J. PANCOAST, M. D., Professor of General, Descriptive, and Surgical Anatomy in the Jefferson Medical College, etc., etc. In two volumes. Philadelphia: 1842. 8vo. pp. 538, 622.

The favourable reception of the last edition of Professor Wistar's Anatomy, enlarged and illustrated, has induced the publication of the present one. The additions of Professor Horner are retained, and the work has been entirely remodelled by Professor Pancoast. The amount of original matter added is so great and of such importance, as to give it almost the character of an original work. We confess that we are no admirers of these mosaic productions, and we are sorry that Dr. Pancoast did not favour us with a treatise of his own. We regret this the more from the ability which he has displayed in the discharge of his editorial duties. He has placed the present work quite *au niveau* of the actual state of anatomical science. His chief additions have been made to the departments of general and microscopic anatomy, and he has here displayed much research and judgment. The present edition is illustrated with eight coloured copper-plate engravings of the blood-vessels, and upwards of two hundred and twenty wood-cuts, and its general appearance is highly creditable.

FOREIGN CORRESPONDENCE.

PARIS, Dec. 15, 1842.

Opening of the Faculty of Medicine.—Prof. Trousseau's Address.—Large doses of the Sulphate of Quinine in Rheumatism.—Its Contra-Stimulant Action.—Claims of Rasori to this Treatment.—Serious accidents in five cases from this treatment, and two deaths. The Discussion on Tenotomy at the Academy of Medicine.—MM. Guérin, Bouvier, and Velpeau.

To the Editor of the Medical Examiner.

Sir,—The School of Medicine opened its annual course, as usual, by public session, for the distribution of the prizes awarded during the vacation. It was generally understood that the opening address would be delivered by Dr. Trousseau. The great reputation of this young and handsome professor as an orator excited general curiosity, and at an early hour the great hall was quite filled. The subject was a parallel between the numerical method and that by induction. It was indeed a brilliant and spirited attack on statistics, which he accused of retarding the progress of science, of fettering the mind, and of reducing the physician to play the character of a mere mechanical counter, without any exercise of intellect on his part. It was better, he said, to advance in darkness, than to stand still. His whole address was listened to with the greatest attention and enthusiasm, and was loudly and frequently applauded. Its diction was elegant and choice; its delivery easy and graceful; and its philosophic character was relieved by agreeable and racy anecdotes.

Dr. Briquet lately communicated to the Academy of Medicine an interesting paper on the employment of sulphate of quinine in large doses in acute rheumatism, in the inflammatory stage. Dr. Rognetta, an Italian oculist, of Paris, has since addressed a letter to the Academy, in which he claims the priority of this practice for Rasori, who, proved, he says, long ago, that the true action of quinine and its preparations was contra-stimulant, and he was hence led to prescribe it in a number of acute and chronic inflammations, and, amongst others, in acute rheumatism. Dr. Mojon, of Genoa, employed the sulphate of quinine in an epidemic of acute rheumatism in 1829, and with the greatest success. Dr. Giacomini, in his Treatise on Therapeutics, states, that from experiments made upon himself, upon patients, and upon animals, he has ascertained that the sulphate of quinine has a very decided hyposthenic action upon the arterial system, and hence recommends its employment in connection with blood-letting in inflammatory affections. Dr. Rognetta adds, that he himself employs, with decided advantage, the salts of quinine in acute ophthalmia, hyposthenic and congestive amaurosis, in gastritis, and in dropsy, symptomatic of abdominal phlogosis. In a series of experiments lately introduced by Dr. Giacomini, he found that the solution of the sulphate of quinine administered in large doses, determined a genuine hyposthenic intoxication, which was only dissipated by the use of mercury, opium, canella, &c. Dr. Rognetta thinks with the Italian physicians, that the limits of tolerance should not be exceeded, and that beyond this a species of poisoning may be induced, known by deafness, blindness, hallucinations, hæmaturia, &c. Dr. Rognetta in conclusion thus resumes his letter:—

1. That the method in question belongs to the Rasorian school.
2. That this method proves the hyposthenic action of the salts of quinine.
3. That we ought not, in the use of this method, to exceed the limits of tolerance.

4. That we can advantageously combine with it the practice recommended by Dr. Bouillaud, (bleeding, *coup sur coup*.)

5. That the combination of the preparations of opium with those of quinine are contra-indicated.

Five severe accidents have lately resulted from this practice, of which two have terminated fatally. Two of these cases occurred at the Hôpital Cochin, and one at La Charité. One patient died immediately after swallowing, at a single dose, *seventy-six and a half grains* (5 grammes) of the salt. At the Hôpital Cochin, a woman labouring under chronic rheumatism, or a disease so called, succumbed soon after the administration of a large dose of the sulphate. A young girl, after the use of the same medicine, became affected with amaurosis, which has already existed for three weeks, in spite of the most appropriate and energetic treatment. The patient at La Charité experienced, at first, pain in the head, then tinnitus, and general agitation, and finally violent delirium, terminating in coma. From this condition he recovered only by the employment of the most active and violent remedies, and after all hope of safety had been abandoned. Except some grave complication interferes with its ordinary termination, acute rheumatism, we all know, is rarely fatal. When death occurs, it is from a phlegmasia of some serous or fibro-serous tissue, and more particularly those of the heart. How then does it happen, that just at the moment these huge doses of the sulphate of quinine become fashionable, acute rheumatism should become so fatal a disease? Is it a singular and inexplicable coincidence? What are the symptoms which precede death in these cases? The usual ones which follow the exhibition of over doses of this medicine, and none other. Is not a demand for future observations a demand for fresh victims? Are there not simpler and surer means of discovering the cause of this extraordinary mortality? Should not humanity and reason dictate that we should suspend this new treatment, and then see if the mortality persists. It has been urged that for a long time Dr. Piorry, of La Pitié, has been in the habit of administering quinine in enormous doses—from a dram to a dram and a half—and without any unpleasant consequences. There is, in the first place, no analogy in the two cases. Dr. Piorry's cases were all intermittent fevers. Does it follow that because a remedy is useful in one disease, it must be so in all others? Besides, Dr. Piorry employs also the neutral salt; whereas that given now is the acid sulphate, which is far more soluble, and probably more is absorbed of it. Moreover, Dr. Piorry now asserts that he obtains the same results from doses of fifteen grains, as he did formerly from those of seventy and ninety grains.

Dr. Serres has just read a very elaborate and favorable report on Mr. Nasmyth's Memoir on the Structure of the Teeth.

A spirit of hyper-therapeutics seems to be becoming fashionable, and if one hospital physician announces as his dose *ten grains* of opium, a *confrère* unwilling to be outdone, in the next day's journal informs the public that he always gives *twelve grains*, and with invariable success. The surgeons, not to be outdone by the physicians, are pursuing pretty much the same plan with regard to tenotomy. This subject, however, has lately been taken hold of seriously by the Academy of Medicine, and I propose to give you a sketch of their proceedings in relation to it, when concluded. It has occupied the Academy since October, and has excited a great deal of interest. There has been a good deal of sharp discussion between MM. Guérin, Bouvier, Velpeau, Gerdy, &c.